DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 5

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1,2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.230

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 258,894
b. FFY 2002 $ 300,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A Page 7.3.1(a), (b) & (c)
Attachment 3.1-B Page 24, 25 & ~~25~~ 25.1
Attachment 4.19-B Page 20.14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A Page 7.3.1, 7.3.1(a) 7.3.2
Attachment 3.1-B Page 24, 24.1, and 25
Attachment 4.19-B Page 20.14

10. SUBJECT OF AMENDMENT:
Durable Medical Equipment

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Review delegated to Interim Commissioner Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Ellen Pesen

14. TITLE:
Interim Commissioner
Department for Medicaid Services

15. DATE SUBMITTED: 3/30/01

16. RETURN TO:
Sharon Rodriguez, Manager
Policy Coordination Branch
Department for Medicaid Services
275 East Main Street 6S-A
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
March 30, 2001

18. DATE APPROVED:
June 26, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Granger

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

7. Home Health Care Services

7.a. Intermittent or Part-time Nursing Service

1. There are no limitations on the intermittent or part-time nursing service provided by the home health agency.

2. There are no limitations on the intermittent or part-time nursing service provided by the registered nurse when no home health agency exists in the area except that the registered nurse must be approved by the local health department serving that area as capable of performing the service.

3. Home health agencies may provide disposable medical supplies necessary for, or related to, the provision of intermittent or part-time nursing service as specified for coverage by the Medicaid Program.

7.b. Homehealth Aide

Services are provided in accordance with the treatment plan.

7.c. Medical Supplies, Equipment, Prosthetics, and Orthotics Suitable for Use in the Home

Each Provider desiring to participate as a durable medical equipment, prosthetic, orthotic, or medical supply provider must be a participating Medicare provider and sign a provider agreement with the Department for Medicaid Services.

Durable medical equipment, prosthetics, orthotics, and medical supplies are covered only in accordance with the following conditions:

1. The Department covers items specified in the Medicare region C DMERC DMEPOS Suppliers Manual. The provider may, however, submit requests for other specific items not covered by Medicare or not routinely covered by the Medicaid Program for consideration.

The provider submits a certificate of medical necessity (CMN) and, if required, a prior authorization form and any other documentation to support medical necessity. Unless specifically exempted by the Department, DME items, supplies, prosthetics, and orthotics will require a CMN completed by the prescriber that will be used by the department to document medical necessity.

2. Coverage of durable medical equipment and supplies, prosthetics, and orthotics for use of patients in the home is based on medical necessity and the requirements of 42 CFR 440.230(c).

   Coverage criteria established by the Medicare program will be used as a guide in determining medical necessity but will be subject to a medical necessity override.

3. Any equipment, prosthetic, orthotic, or supply billed (either purchased or repaired) at $300 or more must be prior authorized by the Department.

4. The criteria used in the determination of medical necessity includes an assessment of whether the item is:
   a. Provided in accordance with 42 CFR 440.230;
   b. Reasonable and required to identify, diagnose, treat, correct, cure, ameliorate, palliate, or prevent a disease, illness, injury, disability, or other medical condition;
   c. Clinically appropriate in terms of amount, scope, and duration based on generally accepted standards of good medical practice;
   d. Provided for medical reasons rather than primarily for the convenience of the recipient, caregiver, or the provider;
   e. Provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;
   f. Needed, if used in reference to an emergency medical service, to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; and,

g. Provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in 42 USC 1396d(r) and 42 CFR 441 Subpart B, for recipients under twenty-one (21) years of age.

5. An item of durable medical equipment, prosthetic, or orthotic shall be durable in nature and able to stand repeated use. Coverage of an item of durable medical equipment, prosthetic, orthotic, or medical supply shall be in accordance with the following: shall serve a medical purpose; shall not generally be useful to a person in the absence of illness or injury; shall be appropriate for use in the home; and shall be medically necessary, and reasonable.

6. The following general types of durable medical equipment, prosthetics or otheotics are excluded from coverage under the durable medical equipment program:

   a. Items which would appropriately be considered for coverage only through other sections of the Medicaid Program, such as frames and lenses, hearing aids, and pacemakers;
   b. Items which are primarily and customarily used for a non-medical purpose, such as air conditioners and room heaters;
   c. Physical fitness equipment, such as exercycles and treadmills; and,
   d. Items which basically serve a comfort or convenience function or which are primarily for convenience of the recipient or the person caring for the recipient, such as elevators and stairway elevators.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility

1. Audiology services are not provided under this component.

2. Physical therapy, occupational therapy, or speech pathology services provided by a medical rehabilitation facility are not provided under this component.

9. Clinic Services

Coverage for clinic services is limited to services provided by the following clinics and includes:

1. Mental health centers licensed in accordance with applicable state laws and regulations. However, services rendered by community mental health centers to skilled nursing or intermediate care facility patients/residents are not covered.
2. Family planning clinics.
3. Clinics engaging in screening for the purposes of the early and periodic screening, diagnosis, and treatment component of the Medicaid Program.
4. Out-patient surgical clinics.
5. Other clinics authorized under 42 CFR 440.90.

7. Home Health Care Services

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XIV. Durable Medical Equipment, Supplies, Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice plus twenty-two (22) percent, not to exceed the supplier's usual and customary charge.

b. Customized components that do not have an HCPC code will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

c. DME items that do not have HCPC codes will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

d. Specialized wheelchair bases will require prior-authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (15) percent, not to exceed the supplier's usual and customary charge.